SERFF Tracking Number:	*CMBD-127613763*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49752*
Company Tracking Number:	*301700-AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Reinstatement Application*		
Project Name/Number:	*301700-AR/301700-AR*		

Filing at a Glance

Company: Combined Insurance Company of America

Product Name: Life Reinstatement Application	SERFF Tr Num: CMBD-127613763	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49752
Sub-TOI: L08.000 Life - Other	Co Tr Num: 301700-AR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Anita Sibley	Disposition Date: 09/13/2011
	Date Submitted: 09/09/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 301700-AR	Status of Filing in Domicile: Pending
Project Number: 301700-AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 09/13/2011
	State Status Changed: 09/13/2011
Deemer Date:	Created By: Anita Sibley
Submitted By: Anita Sibley	Corresponding Filing Tracking Number:

Filing Description:

Form No. 301700-AR – Life Reinstatement/Existing Policy Upgrade Application
Form No. 301700-1 – Conditional Receipt
Individual Life Insurance

This is a new filing. Form No. 301700-AR is a new form which will not replace any existing form. Form No. 301700-AR is a reinstatement/existing policy upgrade application, which will be used in connection with Life Insurance Policies previously approved by your Department. Form No. 301700-1 is the conditional receipt. The application will be solicited on a face-to-face basis by our Insurance Producers or by direct market for telephone and mail solicitation.

SERFF Tracking Number:	*CMBD-127613763*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49752*
Company Tracking Number:	*301700-AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Reinstatement Application*		
Project Name/Number:	*301700-AR/301700-AR*		

Please consider the arrangement of the information on the application as variable. The information may be rearranged to accommodate computer systems or marketing needs but the information will remain the same. The variable bracketed areas are all inclusive. A variable memorandum is attached for your reference. Also attached are the required Certificate of Compliance and Readability Certification.

Thank you for your consideration of this submission. If you have any questions or concerns, please feel free to contact me.

Company and Contact

Filing Contact Information

Anita Sibley, Policy Analyst	Anita.Sibley@combined.com
1000 N Milwaukee Avenue	847-953-1526 [Phone]
6th Floor	847-953-1557 [FAX]
Glenview, IL 60025	

Filing Company Information

Combined Insurance Company of America	CoCode: 62146	State of Domicile: Illinois
1000 Milwaukee Avenue	Group Code: 626	Company Type:
Glenview, IL 60025	Group Name:	State ID Number:
(847) 953-1531 ext. [Phone]	FEIN Number: 36-2136262	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	1 Application and 1 Conditional Receipt = 2 filed forms at $50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Combined Insurance Company of America	$100.00	09/09/2011	51443947

SERFF Tracking Number:	*CMBD-127613763*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49752*
Company Tracking Number:	*301700-AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Reinstatement Application*		
Project Name/Number:	*301700-AR/301700-AR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/13/2011	09/13/2011

SERFF Tracking Number:	*CMBD-127613763*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49752*
Company Tracking Number:	*301700-AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Reinstatement Application*		
Project Name/Number:	*301700-AR/301700-AR*		

Disposition

Disposition Date: 09/13/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMBD-127613763*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49752*
Company Tracking Number:	*301700-AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Reinstatement Application*		
Project Name/Number:	*301700-AR/301700-AR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Variability Memorandum		Yes
Form	Life Reinstatement/Existing Policy Upgrade Application		Yes
Form	Conditional Receipt		Yes

SERFF Tracking Number:	*CMBD-127613763*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49752*
Company Tracking Number:	*301700-AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Reinstatement Application*		
Project Name/Number:	*301700-AR/301700-AR*		

Form Schedule

Lead Form Number: 301700-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	301700-AR	Application/ Enrollment Form	Life Reinstatement/Existing Policy Upgrade Application	Initial		48.110	301700-AR.pdf
	301700-1	Other	Conditional Receipt	Initial			301700-1.pdf

COMBINED INSURANCE COMPANY OF AMERICA
[111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]
I am applying for a life policy revision based on the following information.

[7401301700]

[7 4 0 1]

[X] **Reinstatement** [X] **Existing Policy Upgrade**

This application can only be used for **LIFE**

Section 1 – BASIC INFORMATION *(Required for all products)*

LANGUAGE PREFERENCE [X] E [X] S [X] F

SEX M [X] F [X] | INSURED'S FIRST NAME | MIDDLE INITIAL | LAST NAME

INSURED'S RESIDENCE ADDRESS

CITY | STATE | ZIP

Do you have a [mobile phone]? [X] YES [X] NO PHONE NUMBER

SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

Do you have a [landline phone]? [X] YES [X] NO PHONE NUMBER

INSURED'S DATE OF BIRTH MM DD YYYY | INSURED'S AGE

EMAIL

May we contact you by email for marketing purposes? [X] YES [X] NO

MAILING ADDRESS FOR COMPANY CORRESPONDENCE *(ONLY IF DIFFERENT FROM RESIDENCE ADDRESS)*

CITY | STATE | ZIP CODE

Is any person applying for coverage on Medicaid? [X] YES [X] NO If "Yes" whom: [X] Insured [X] Spouse [/Domestic Partner/Civil Union]

[X] Child(ren) Name(s) of Child(ren): _____

(Any person who is currently a Medicaid Recipient is not eligible for [reinstatement or the upgrade] being applied for.)

Is the above information all correct? [X] YES [X] NO (If "no", complete Address Change form.)

(Required ONLY if Owner is different from Insured)

OWNER'S NAME

OWNER'S RESIDENCE ADDRESS

CITY | STATE | ZIP

Do you have a [mobile phone]? [X] YES [X] NO PHONE NUMBER

Do you have a [landline phone]? [X] YES [X] NO PHONE NUMBER

OWNER'S E-MAIL

OWNER'S MAILING ADDRESS (ONLY IF DIFFERENT FROM RESIDENCE ADDRESS)

CITY | STATE | ZIP

[7402301700]

Section 2 – INSURANCE POLICY WHICH [REINSTATEMENT OR UPGRADE] IS APPLIED FOR

POLICY NUMBER

AMOUNT OF INSURANCE $, ,

RENEWAL/MODAL PREMIUM $.

[Please complete only if upgrading an existing policy.]

X **Child Term Rider** Term _____

X **Insured Term Rider** Term _____

X **Spouse Term Rider** Term _____

X Insured Accidental Death Rider

X Spouse Accidental Death Rider

X Child Accidental Death Rider

X Increase Child Term Amount to $ _____

X Increase Insured Term Amount to $ _____

X Increase Spouse Term Amount to $ _____

DEPENDENT COVERAGE:

[For reinstatement purposes, only those dependents covered under the previous policy are eligible.] [If applying to add dependent(s) via upgrading, list the full name, date of birth for each dependent and social security number.]

SPOUSE'S [/DOMESTIC PARTNER/CIVIL UNION] FIRST NAME | MIDDLE INITIAL | LAST NAME | SPOUSE'S [/DOMESTIC PARTNER/CIVIL UNION] DATE OF BIRTH M M D D Y Y Y Y

SOCIAL SECURITY NUMBER [(LAST 4 DIGITS)]

Child's Name (First Last) | Birthdate: Mo/Day/Yr

(1) M M D D Y Y

SOCIAL SECURITY NUMBER [(LAST 4 DIGITS)]

(2) M M D D Y Y

SOCIAL SECURITY NUMBER [(LAST 4 DIGITS)]

(3) M M D D Y Y

SOCIAL SECURITY NUMBER [(LAST 4 DIGITS)]

(4) M M D D Y Y

SOCIAL SECURITY NUMBER [(LAST 4 DIGITS)]

(For additional children include separate sheet.)

Golden Advantage Plus (GAP) (REINSTATEMENT ONLY)

This section to be used to qualify for Golden Advantage Plus, only.

Has the Insured been diagnosed with a terminal condition with less than 2 years to live, or within the last 60 days, has the Insured been hospitalized, confined to a nursing home, received hospice or home health care services?

Insured	
Yes	No
X	X

Section 3 – PREMIUM & BILLING INFORMATION

RENEWAL MODE

X ANNL. X S.A. X MO. X TPP X CC

X Please charge or debit my checking, savings, or credit card account monthly.

Preferred Billing Day (1–28 only)

TOTAL RENEWAL/MODAL PREMIUM $.

INITIAL PREMIUM COLLECTED $.

Form of Initial Payment Collected

Check X Cash X Money Order X Credit Card X

[7403301700]

Section 4 – UNDERWRITING INFORMATION

	Insured		Spouse [/Domestic Partner/Civil Union]	
	Yes	No	Yes	No
Has the Insured or the Insured's Spouse [/Domestic Partner/Civil Union] used tobacco in any form in the last 12 months?	X	X	X	X

INSURED'S DRIVERS LICENSE ____ STATE ____

HEIGHT FT. ____ IN. ____ WEIGHT LBS. ____

SPOUSE'S [/DOMESTIC PARTNER/CIVIL UNION] DRIVERS LICENSE ____ STATE ____

HEIGHT FT. ____ IN. ____ WEIGHT LBS. ____

These questions to be used to qualify for all products except Golden Advantage Plus (GAP).

	Insured		Spouse [/Domestic Partner/Civil Union]		Dependent	
	Yes	No	Yes	No	Yes	No
1. Has the Insured, the Insured's Spouse [/Domestic Partner/Civil Union], or any eligible dependents listed on this application for insurance received any medical ADVICE or TREATMENT from a member of the medical profession, or taken any prescription MEDICINE within the past 5 years for:						
a. Angina, stroke, heart attack, atrial fibrillation, congestive heart failure, or a heart valve replacement?	X	X	X	X	X	X
b. Liver or kidney disorder, cirrhosis of the liver, or organ transplant?	X	X	X	X	X	X
c. Cancer, melanoma, brain tumor, Hodgkin's disease or leukemia?	X	X	X	X	X	X
d. Alzheimer's disease, dementia, Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), or muscular dystrophy?	X	X	X	X	X	X
e. Chronic Obstructive Lung/Pulmonary disease, Emphysema or other lung disease requiring oxygen?	X	X	X	X	X	X
f. Manic depression, schizophrenia, alcoholism or drug addiction?	X	X	X	X	X	X
g. Down's Syndrome, Cerebral Palsy, or Cystic Fibrosis?	X	X	X	X	X	X
2. Are the Insured, the Insured's Spouse [/Domestic Partner/Civil Union], or any eligible dependents listed an insulin dependent diabetic?	X	X	X	X	X	X
3. Has the Insured, the Insured's Spouse [/Domestic Partner/Civil Union], or any eligible dependent listed been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?	X	X	X	X	X	X
4. Has the Insured or the Insured's Spouse [/Domestic Partner/Civil Union] been convicted of reckless driving or driving under the influence of alcohol within the past 5 years?	X	X	X	X		
5. Have 2 or more of the Insured's parents, brothers or sisters been diagnosed with cancer or any malignant growth while they were under the age of 60?	X	X	X	X	X	X
6. Have 2 or more of the Insured's parents, brothers or sisters been diagnosed with heart disease while they were under the age of 60?	X	X	X	X	X	X

If any of the above questions are answered "Yes", the Insured, the Insured's Spouse [/Domestic Partner/Civil Union], or eligible dependents are not eligible for coverage.

7. Are the Insured, the Insured's Spouse [/Domestic Partner/Civil Union], or any eligible dependent children listed on the application for insurance a non-insulin dependent diabetic taking oral medication and/or treated by diet?	X	X	X	X	X	X
8. Has the Insured or the Insured Spouse [/Domestic Partner/Civil Union] applied for or received any disability payments from Social Security or Workers' Compensation within the past 2 years?	X	X	X	X		
9. Within the past 5 years have you, your Spouse [/Domestic Partner/Civil Union] or eligible dependent children listed on the application for insurance had any medical advice or treatment from a member of the medical profession or taken any prescription medications for any other medical condition(s) not listed above?	X	X	X	X	X	X

(If "Yes" is answered to question 7, 8, or 9, explain below.) In any case, please provide information on your physician.

Name of Insured/ Spouse [/Domestic Partner/Civil Union]/Dep.	Health Condition	Date of Diagnosis	Medication/Dosage/ Treatment Received	Dates	Physician(s) Name, Address (Street, City, State, Zip) & Phone
				From: To:	
				From: To:	
				From: To:	

[7404301700]

Section 5

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions made in writing or orally for any portion(s) of the application that is completed through use of the telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, Notice of Information Practices, and (if applicable) Accelerated Benefit Disclosure.
3. I understand that the terms and conditions for the Incontestability of my existing policy shall apply to any incremental increase in benefit amount(s) applied for with this application from the date the company approves such incremental increase for my existing policy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from the following: Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically related facilities; Government Agency; Medical Information Bureau, Inc., (MIB); Consumer Reporting Agency; Combined's own records. Combined Insurance Company of America will acquire through a personal phone interview or another means from the above any needed information on the Insured, his/her dependents including but not limited to copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance. Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules.

This authorization shall remain valid for a period of two years from the date of application. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company. Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

X _____ Signature of Applicant/Owner (if different than Insured)

X _____ Signature of Insured

X _____ Signature of Spouse [/Domestic Partner/Civil Union] (when applying as a rider)

City (where signed): _____ State: _____ Date: ____/____/____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I, the authorized agent/producer, have on the Date of Application recorded the information as given to me by the Owner. [I have delivered the Notice of Information Practices, and where applicable, the Accelerated Benefit Disclosure.] I have no knowledge of any unfavorable medical history not recorded on this Application. I certify that I have inspected this application for completeness, witnessed the applicant's signature, and according to our field underwriting guidelines it may be submitted to the Home Office for further underwriting review.

Licensed Agent/Producer _____ (print) Code # _____

Sales Manager _____ (print) Code # _____

Agent's/Producer's Signature _____

Manager's Signature _____ Code # _____

Date MM DD YYYY

Primary Agent/Producer contact information

Agent's/Producer's phone
Agent's/Producer's e-mail address
Agent's/Producer's cell phone

Home Office use only

Complete this area when splitting commissions.	
Primary	Secondary
Agent/Producer Name	Agent/Producer Name
Code #	Code #
Percentage	Percentage
Agent's/Producer's Signature	Agent's/Producer's Signature

[7405]

[7405301700]

AUTOMATIC PREMIUM COLLECTION (Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

Complete if adding policies from another application

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking X Savings X Initial Premium Collected $ Policy Type → (L = Life, H = Health)

Credit Card X

Preferred Billing Date (1–28 only) Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

AUTHORIZATION FOR ELECTRONIC DEBIT: I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking, savings, or credit card account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.
I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule. I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Date: MM DD YYYY X Mobile X Landline

Signature of Payor/Cardholder (Signature must be the same as on file at the bank/financial institution or represent an authorized signee for a business account.)

COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]
[www.combinedinsurance.com]

Application No.		Amount of Insurance	$

CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY

I have applied for insurance from Combined Insurance Company of America (Combined Insurance).
With my insurance application I have submitted a check, money order, cash or credit card in the amount of: $

This receipt shall be void and no coverage applied for will take effect if any instrument given in payment of the first premium is not honored.

I understand that this payment will be held by Combined Insurance and, if my application is approved and a policy is issued to me, Combined Insurance will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that the policy(ies) I applied for will NOT become effective unless my initial premium has been paid, the application is approved in writing by Combined Insurance and the applicable policy is delivered to me. I understand that if Combined Insurance approves my application, I will have coverage beginning on the date of such approval by Combined Insurance. If my application is not approved by Combined Insurance, the above premium will be immediately refunded to me.

I understand that in no event will I have coverage for the period between the date of this receipt and the date on which Combined Insurance disapproves or approves my application and issues my policy(ies). The application shall be deemed declined if the policy(ies) is (are) not issued within 60 days after the date of application.

Proposed Insured's Signature

Sales Representative's Signature Code #

Date MM DD YYYY

[7405301700]

[7 4 0 5]

AUTOMATIC PREMIUM COLLECTION (Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

Complete if adding policies from another application

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking X Savings X Initial Premium Collected $ Policy Type → (L = Life, H = Health)

Credit Card X

Preferred Billing Date (1–28 only) Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

AUTHORIZATION FOR ELECTRONIC DEBIT: I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking, savings, or credit card account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.
I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule. I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Date: M M D D Y Y Y Y X Mobile X Landline

Signature of Payor/Cardholder (Signature must be the same as on file at the bank/financial institution or represent an authorized signee for a business account.)

COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]
[www.combinedinsurance.com]

Application No.		Amount of Insurance	$

CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY

I have applied for insurance from Combined Insurance Company of America (Combined Insurance).
With my insurance application I have submitted a check, money order, cash or credit card in the amount of: $

This receipt shall be void and no coverage applied for will take effect if any instrument given in payment of the first premium is not honored.

I understand that this payment will be held by Combined Insurance and, if my application is approved and a policy is issued to me, Combined Insurance will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that the policy(ies) I applied for will NOT become effective unless my initial premium has been paid, the application is approved in writing by Combined Insurance and the applicable policy is delivered to me. I understand that if Combined Insurance approves my application, I will have coverage beginning on the date of such approval by Combined Insurance. If my application is not approved by Combined Insurance, the above premium will be immediately refunded to me.

I understand that in no event will I have coverage for the period between the date of this receipt and the date on which Combined Insurance disapproves or approves my application and issues my policy(ies). The application shall be deemed declined if the policy(ies) is (are) not issued within 60 days after the date of application.

Proposed Insured's Signature

Sales Representative's Signature Code #

Date M M D D Y Y Y Y

SERFF Tracking Number:	*CMBD-127613763*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49752*
Company Tracking Number:	*301700-AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life Reinstatement Application*		
Project Name/Number:	*301700-AR/301700-AR*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachments:
Certification of Compliance.pdf
FleschCertification.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: The application is being filed for approval and is included in the Forms Schedule.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Variability Memorandum
Comments:
Attachment:
301700-AR Variability Memorandum.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Combined Insurance Company of America

Form Number(s): 301700-AR - Life Reinstatement/Existing Policy Upgrade Application
301700-1 - Conditional Receipt

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Michael J. Hollar
Name

Assistant Secretary
Title

September 9, 2011
Date

September 9, 2011

READABILITY CERTIFICATION

RE: Form No. 301700-AR – Life Reinstatement/Existing Policy Upgrade Application

We hereby certify that the above captioned form has a Flesch Index Score of 48.110 and meets the reading ease requirements.

Michael J. Hollar
Assistant Secretary

COMBINED INSURANCE®

Variability Memorandum
Form No. 301700-AR and Form No. 301700-1

Variables for 301700-AR

	Bracketed Information	Options/Reasons
Variables that occur on multiple pages		
1	Bar Code and Application Numbers	Internal Tracking and Scanning Information for each printed application. Numbering sequence may change depending on computer system(s) used.
2	Reinstatement	All references are bracketed and may be deleted if an Existing Policy Upgrade is the only option being offered.
3	Upgrade *or* Existing Policy Upgrade	All references are bracketed and may be deleted if a Reinstatement is the only option being offered.
4	Social Security Number	Bracketed to allow us the option to: obtain the full SSN; limit the SSN to the last four digits; or remove the SSN in its entirety.
5	Spouse/Domestic Partner/Civil Union	Bracketed to address current and/or future state mandates regarding coverage availability for Civil Unions or Domestic Partnerships. Options include: Spouse; Spouse/Domestic Partner; or Spouse/Civil Union Partner.
Page 1 variables: Section 1 – BASIC INFORMATION		
6	Home Office Address	Bracketed to address any future change in our Home Office Address
7	Language Preference	The entire line will be removed if offered only in English. Individual check boxes may be removed depending on language options being offered.
8	Mobile Phone or Landline Phone	Bracketed to accommodate changes in technology and or phone terminology.
9	May we Contact you by email for marketing purposes?	All-inclusive. May be deleted if we decide not to use this field.
10	Alternate Mailing Address	All-inclusive. May be deleted if not needed for business purposes.
11	Is the above information all correct?	All-inclusive. May be deleted if we decide not to use this field.
Page 2 variables: Section 2 – INSURANCE POLICY WHICH REINSTATEMENT OR UPGRADE IS APPLIED		
12	Please complete only if upgrading an existing policy.	All inclusive. May be deleted if an Existing Policy Upgrade is not being offered.
13	Rider Coverage Options	All inclusive. May be deleted if an Existing Policy Upgrade is not being offered.
14	For reinstatement purposes, only those dependents covered under the previous policy are eligible.	All inclusive. May be deleted if a Reinstatement is not being offered.

15	If applying to add dependent(s) via upgrading, list the full name, date of birth for each dependent and social security number.	All inclusive. May be deleted if an Existing Policy Upgrade is not being offered.
16	Gold Advantage Plus Coverage Option	All inclusive. May be deleted if a Reinstatement is not being offered.
Page 2 variables: Section 3 – PREMIUM & BILLING INFORMATION		
17	Renewal Modes	Bracketed to allow for the removal of one or more modal options.
18	Please charge or debit my checking, savings, or credit card account monthly.	May be removed in its entirety, or modified to remove one or more deduction options.
19	Initial Premium Collected	All inclusive. May be deleted if premium not to be collected at time of application
20	Form of Initial Payment Collected	All inclusive. May be deleted if premium not to be collected at time of application.
Page 4 variables: Section 5 – PLEASE READ CAREFULLY		
21	2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, Notice of Information Practices, and if applicable Accelerated Benefit Disclosure.	May be modified to add reference to any other disclosures that may be required in the future.
22	3. I understand that the terms and conditions for the Incontestability of my existing policy shall apply to any incremental increase in benefit amount(s) applied for with the application from the date the company approves such incremental increase for my existing policy.	All inclusive. May be deleted if an Existing Policy Upgrade is not being offered.
23	Agent Declarations	All inclusive. May be deleted for Direct Response upgrades or reinstatements.
24	I have delivered the Notice of Information Practices, and where applicable, the Accelerated Benefit Disclosure.	May be modified to add reference to any other disclosures that may be required in the future.
25	Primary Agent/Producer contact information	All inclusive. May be deleted for Direct Response upgrades or reinstatements.
26	Home Office use only	All inclusive. May be deleted if Company decision is to not offer split commission.

Variables for 301700-1

27	Automatic Premium Collection	All inclusive. May be deleted if it is decided to have Automatic Premium Collection as a separate document.
28	Charge my: Checking; Savings; Credit Card	May be removed in its entirety, or modified to remove one or more deduction options.
29	Preferred Billing Date (1-28 only)	All inclusive. May be deleted if we decide not to use this field.
30	Name of Cardholder / Account Information	All inclusive. May be deleted if we decide not to use this field.
31	Home Office Address	Bracketed to address any future change in our Home Office Address
32	www.combinedinsurance.com	Bracketed to address any future change in our corporate website